



Student Authorization Agreement for Automatic Payroll Deposits

PLEASE NOTE: Auxiliary Services' Student Employees can **access their earnings slip via a secure website**. User name and initial password information will be emailed to your **SUNY Oswego email account** prior to your first direct deposit.

Student Employee Name: _____ Phone: _____

Work Location: _____ **SUNY OSWEGO EMAIL:** _____ **@oswego.edu**

I hereby authorize Auxiliary Services, and the **Financial Institution** named below, to initiate deposits (ACH credit entries) to my **Account** (hereinafter called **Account**). I also authorize Auxiliary Services and the Financial Institution to initiate, if necessary, any debit entries and adjustments for any credit entries made in error to my **Account**.

Financial Institution: _____ City/State/Zip: _____

Transit/ABA# (9 digits) _____ Account # _____

Please note: Debit cards do not have the correct account number. Information for this form should come from your check/deposit slip (with your name pre-printed on it, NO STARTER checks) or Financial Institution representative.

Account Type: [] **Checking Account** (Attach a voided check or deposit (MUST be pre-printed with your name), or have your Financial Institution representative complete both the ABA/Account # sections AND the box below.)

[] **Savings Account** (Have your Financial Institution representative complete the ABA # sections AND the box below.)

If you do not have a check or deposit slip **pre-printed with your name**, please have your Financial Institution representative complete the Transit/ABA and Account information sections, and complete the areas below.

_____	_____
Financial Institution Representative (print name)	Office Location & Contact Phone
_____	_____
Financial Institution Representative (signature)	Date

I give authorization to deposit (credit) 100% of net pay (my entire check) to this **Account**.

This authorization is to remain in full force and effect until Auxiliary Services has received written notification from me to terminate it. Upon receipt of notification to terminate this authorization, Auxiliary Services and the **Financial Institution** shall have reasonable time and opportunity to act on it.

Account Holder (please print)

Signature

Date

STUDENT MUST RETURN THIS FORM IN PERSON TO ROOM 506 CULKIN HALL